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The Right to Refuse Life Sustaining Medical Treatment and the Noncompetent Nonterminally Ill Patient: An Analysis of Abridgment and Anarchy

Dying
Is an art, like everything else.*

I. INTRODUCTION

Nancy Beth Cruzan has been condemned to live.¹ The Supreme Court of Missouri² has condemned Nancy to live for the next thirty years³ in a persistent vegetative state⁴ because it failed to uphold Nancy's right to terminate artificial nutrition and hydration as exer-

* Plath, *Lady Lazarus*, in 2 THE NORTON ANTHOLOGY OF AMERICAN LITERATURE 2566 (2d ed. 1985).

1. *Cruzan v. Harmon*, 760 S.W.2d 408 (Mo. 1988), cert. granted sub nom. *Cruzan v. Director, Mo. Dep't of Health*, 109 S. Ct. 3240 (1989). On January 11, 1983, in Jasper County, Missouri, Nancy Beth Cruzan was in a near fatal automobile accident. As a result of the accident, she was without oxygen for approximately 12 to 14 minutes. *Id.* at 410-11. Thereafter, Nancy lapsed into a coma from which she has never recovered. In February 1983, a feeding tube was surgically inserted to provide nutrition and hydration, as Nancy was unable to receive food or water orally. *Id.* at 431. Subsequently, she was found to be in a persistent vegetative state, although not terminally ill. According to medical testimony, she can live another 30 years in this condition. *Id.* at 411.

Nancy's parents, as her appointed co-guardians, sought court approval to have the state hospital discontinue all further artificial nutrition and hydration. The trial court granted the request and ordered the hospital to withdraw nutrition and hydration. *Id.* at 410-12. However, the Supreme Court of Missouri reversed the trial court's decision and held that Nancy's co-guardians, her parents, "did not have the authority to order the withdrawal of hydration and nutrition" as an exercise of substituted judgment on Nancy's behalf. *Id.* at 426-27.

The United States Supreme Court has granted certiorari in this case. See *Cruzan v. Director, Mo. Dep't of Health*, 109 S. Ct. 3240 (1989).

2. See *supra* note 1.

3. *Cruzan*, 760 S.W.2d at 411. Nancy currently receives artificial nutrition and hydration through a gastrostomy tube at the Mount Vernon State Hospital. *Id.* at 411 & n.2. As a result of the Missouri Supreme Court's decision, she will remain in this condition indefinitely.

4. A persistent vegetative state [hereinafter PVS] often results from cardiac or respiratory failure accompanied by the absence of blood (ischemia) or oxygen (hypoxia) to the brain. Cranford, *The Persistent Vegetative State: The Medical Reality (Getting the Facts Straight)*, 18 HASTINGS CENTER REP. 27, 27-28 (1988). The PVS patient is characterized by complete unconsciousness and an absence of "[v]oluntary reactions or behavioral responses reflecting consciousness, volition, or emotion at the cerebral cortical level." *Id.* at 28.

cised through her co-guardians, her parents. Thus, the court denied the right of a noncompetent⁵ nonterminally ill⁶ patient to refuse life sustaining medical treatment⁷ as exercised through a surrogate decisionmaker.⁸

Fortuitously, if this action had been brought in another state,⁹ Nancy's right to refuse life sustaining medical treatment would probably have been preserved. However, unlike the majority of states, Missouri has chosen to deny the noncompetent nonterminally ill patient's right to refuse life sustaining medical treatment¹⁰ when the right is exercised by a surrogate decisionmaker through the withdrawal of nutrition and hydration.¹¹ Thus, although the majority of

5. Noncompetency is determined by judicial proceeding, and is characterized by an inability to care for oneself, including the inability to make decisions regarding the acceptance or rejection of life sustaining medical procedures. See *infra* notes 128-30 and accompanying text.

6. A nonterminally ill condition may be characterized by the presence of coma, substantial brain damage, or persistent vegetative state, and the concomitant absence of a terminal condition. A terminal condition is generally defined as an incurable condition which would result in death within a short period of time regardless of the application of life sustaining measures. See *infra* notes 21, 131-33 and accompanying text.

7. The right to refuse life sustaining medical treatment has three bases: (1) the common law right of bodily integrity; (2) the constitutional right of privacy; and (3) the statutory rights embodied in the natural death acts. See *infra* notes 37-74 and accompanying text for discussion.

Medical treatment or procedures used to sustain or prolong the life of the patient are known by various names. See *infra* note 62 for statutes. The American Medical Association [hereinafter AMA] has indicated that life prolonging medical procedures include "medication and artificially or technologically supplied respiration, nutrition or hydration." AMA Council on Ethical and Judicial Affairs, Op. 2.18 (1986) [hereinafter AMA Opinion]. The Uniform Rights of the Terminally Ill Act (URITA) defines life sustaining treatment as "any medical procedure or intervention that, when administered to a qualified patient, will serve only to prolong the process of dying." URITA § 1(4), 9B U.L.A. 611 (1987).

8. The term "surrogate decisionmaker" is used because the decisionmaker may not necessarily be the patient's guardian. See *In re Browning*, 543 So. 2d 258, 261 & n.1 (Fla. Dist. Ct. App. 1989).

9. Many states have upheld the right of the noncompetent patient to refuse life sustaining medical treatment. See cases cited *infra* note 12.

10. *Cruzan v. Harmon*, 760 S.W.2d 408 (Mo. 1988), cert. granted sub nom. *Cruzan v. Director, Mo. Dep't of Health*, 109 S. Ct. 3240 (1989); see also *supra* notes 1-3 and accompanying text. In addition, other states that have not chosen to completely deny the right of the noncompetent nonterminally ill patient, have chosen to abridge or limit the right to refuse life sustaining medical treatment through various measures. For example, the right to refuse medical treatment is often limited to patients who are in a terminal condition, thereby precluding the nonterminally ill patient. Moreover, courts often require "clear and convincing evidence" of an intent to forego medical treatment, which is above and beyond the standard of a preponderance of the evidence which is normally required in a civil case. See, e.g., *In re Peter*, 108 N.J. 365, 377-78, 529 A.2d 419, 425 (1987). Furthermore, natural death acts which allow the termination of life sustaining medical procedures are limited to patients who are in a terminal condition. See *infra* note 62 for statutes.

11. Although most courts treat the withdrawal or withholding of artificial nutrition and hydration in the same way as other life sustaining procedures, some debate remains as to whether nutrition and hydration should be classified as life sustaining medical treatment. Compare *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 1016, 195

states seek to preserve the noncompetent patient's right to refuse medical treatment,¹² the law remains unsettled. Consequently, the noncompetent patient's right to refuse life sustaining medical treatment is subject to a wide spectrum of legal theories and analyses¹³ which often are wrought with disparity and contradiction. The continuum ranges from complete nonrecognition of the noncompetent patient's right to refuse life sustaining medical treatment¹⁴ to preservation of rights which are comparable to those of competent

Cal. Rptr. 484, 490 (1983) (intravenous nutrition and hydration treated same as other life support measures); *In re Severns*, 425 A.2d 156, 160 (Del. Ch. 1980) (use of feeding tube classified as life support measure); *In re Hier*, 18 Mass. App. Ct. 200, 207-08, 464 N.E.2d 959, 964 (1984), *review denied*, 392 Mass. 1102, 465 N.E.2d 261 (1988) (no distinction drawn between nutrition and hydration and other forms of life sustaining treatment); *In re Conroy*, 98 N.J. 321, 372-74, 486 A.2d 1209, 1235-37 (1985) (no distinction between artificial nutrition and other life sustaining treatment) *with* *Leach v. Akron Gen. Medical Center*, 68 Ohio Misc. 1, 12-13 (1980) (distinction between nutrition and hydration and other forms of life sustaining treatment as court only allowed discontinuance of respirator).

12. The right of the noncompetent patient to refuse medical treatment was established in the seminal case of *In re Quinlan*, in which the court held that the noncompetent patient's right should not be discarded due to the noncompetent status of the patient. *In re Quinlan*, 70 N.J. 10, 41, 355 A.2d 647, 664, *cert. denied*, 429 U.S. 922 (1976).

Subsequent cases have followed the *Quinlan* approach and have afforded the noncompetent patient the right to refuse or discontinue medical treatment. *See, e.g.*, *Foody v. Manchester Memorial Hosp.*, 40 Conn. Supp. 127, 140-41, 482 A.2d 713, 721-22 (1984); *Severns*, 425 A.2d at 160; *John F. Kennedy Memorial Hosp., Inc. v. Bludworth*, 452 So. 2d 921, 926 (Fla. 1984); *In re Barry*, 445 So. 2d 365, 371 (Fla. Dist. Ct. App. 1984); *In re L.H.R.*, 253 Ga. 439, 446-47, 321 S.E.2d 716, 722-23 (1984); *In re Spring*, 380 Mass. 629, 640-41, 405 N.E.2d 115, 122-23 (1980); *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 759, 370 N.E.2d 417, 435 (1977); *Hier*, 18 Mass. App. Ct. at 209-11, 464 N.E.2d at 965-66; *In re Torres*, 357 N.W.2d 332, 341 (Minn. 1984); *Conroy*, 98 N.J. at 360, 486 A.2d at 1229; *In re Hamlin*, 102 Wash. 2d 810, 820-21, 689 P.2d 1372, 1378 (1984).

13. *See infra* notes 106-21 and accompanying text. General considerations affecting the noncompetent patient's right to refuse life sustaining medical treatment include the nature of the incompetency (whether the patient has or has not been previously competent), the presence or absence of a terminal or nonterminal condition, and the type of life sustaining medical procedure sought to be withdrawn or withheld (nutrition and hydration or other life sustaining measures).

Once the noncompetent patient is granted the right to refuse medical treatment, an issue arises as to how the right will be exercised on behalf of the patient. Two basic tests are employed to implement the noncompetent patient's right: (1) the substituted judgment test; and (2) the best interests test. *See id.* for a more complete explanation of these tests.

14. *See Cruzan v. Harmon*, 760 S.W.2d 408, 426 (Mo. 1988), *cert. granted sub nom. Cruzan v. Director, Mo. Dep't of Health*, 109 S. Ct. 3240 (1989) (court did not allow withdrawal of artificial nutrition and hydration from noncompetent nonterminally ill patient).

patients.¹⁵

In the majority of states, the competent patient has the right to refuse life sustaining medical treatment.¹⁶ This view is based upon the common law right of bodily integrity,¹⁷ the constitutional right of privacy,¹⁸ and the statutory rights embodied in statutes commonly known as natural death acts.¹⁹ Moreover, most states have extended this right to the noncompetent patient²⁰ who is in a terminal condition.²¹ The right to refuse life sustaining medical treatment is accorded to the noncompetent terminally ill patient based upon the exercise of substituted judgment by a surrogate decisionmaker²² or a determination of the noncompetent patient's best interests.²³

Although the noncompetent terminally ill patient generally has the right to refuse life sustaining medical treatment, the law is less well settled as applied to the noncompetent nonterminally ill pa-

15. See, e.g., *Rasmussen v. Fleming*, 154 Ariz. 207, 741 P.2d 674 (1987) (guardian authorized to exercise noncompetent patient's right to refuse medical treatment); *In re Browning*, 543 So. 2d 258, 270 (Fla. Dist. Ct. App. 1989) (guardian as surrogate decisionmaker allowed to terminate life sustaining measures from noncompetent nonterminally ill patient).

16. See, e.g., *Bartling v. Superior Court*, 163 Cal. App. 3d 186, 193-94, 209 Cal. Rptr. 220, 224 (1984); *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 1014-15, 195 Cal. Rptr. 484, 489 (1983); *Foody v. Manchester Memorial Hosp.*, 40 Conn. Supp. 127, 132, 482 A.2d 713, 718 (1984); *Satz v. Perlmutter*, 362 So. 2d 160, 162-63 (Fla. Dist. Ct. App. 1978), *approved*, 379 So. 2d 359 (Fla. 1980); *Spring*, 380 Mass. at 634, 405 N.E.2d at 119; *Saikewicz*, 373 Mass. at 738-39, 370 N.E.2d at 424; *Conroy*, 98 N.J. at 346-47, 486 A.2d at 1222; *Quinlan*, 70 N.J. at 39-41, 355 A.2d at 663-64; *In re Storar*, 52 N.Y.2d 363, 377, 420 N.E.2d 64, 71, 438 N.Y.S.2d 266, 273, *cert. denied*, 454 U.S. 858 (1981).

17. See *infra* notes 41-45 and accompanying text.

18. See *infra* notes 46-61 and accompanying text.

19. See *infra* notes 62-74 and accompanying text.

20. The right of the noncompetent patient to refuse life sustaining medical treatment was first established in the aforementioned *Quinlan* case. The *Quinlan* court stated that "[t]he only practical way to prevent destruction of the right is to permit the guardian and family . . . to render their best judgment . . . as to whether [the noncompetent patient] would exercise it in these circumstances." *Quinlan*, 70 N.J. at 41, 355 A.2d at 664; see also *supra* note 12.

21. The terminally ill patient is frequently defined as one who has an incurable condition which would result in death regardless of the use of life sustaining measures. The California Natural Death Act, CAL. HEALTH & SAFETY CODE §§ 7185-7195 (West Supp. 1989), is illustrative of the definitions of terminal condition contained in the natural death acts. The California Natural Death Act defines terminal condition as "an incurable condition caused by injury, disease, or illness, which, regardless of the application of life sustaining procedures, would, within reasonable medical judgment, produce death, and where the application of life sustaining procedures serve only to postpone the moment of death of the patient." *Id.* § 7187(f). Similarly, the Uniform Rights of the Terminally Ill Act (URITA) defines terminal condition "as incurable and irreversible condition that, without the administration of life-sustaining treatment, will, in the opinion of the attending physician, result in death within a relatively short time." URITA § 1(9), 9B U.L.A. 48 (Supp. 1989) (section amended 1989).

22. See *infra* notes 111-17 and accompanying text for a discussion of the "substituted judgment" test.

23. See *infra* notes 118-21 and accompanying text for a discussion of the "best interests" test.

tient.²⁴ This comment proposes that the noncompetent nonterminally ill patient be granted the full complement of rights to refuse life sustaining medical treatment, including the removal of nutrition and hydration, regardless of the nonterminal status of the patient.²⁵

Part II will explore and analyze the competent patient's right to refuse life sustaining medical treatment based upon the common law right of bodily integrity,²⁶ the constitutional right of privacy,²⁷ and the statutory rights embodied in the natural death acts,²⁸ as balanced against the countervailing state interests.²⁹ Part III will analyze the extension of the right to refuse life sustaining medical treatment to the noncompetent terminally ill patient. In addition, Part III will focus on the manner in which the right is exercised on behalf of the noncompetent patient, encompassing both the noncompetent patient who has been previously competent and the noncompetent patient who has never been competent.³⁰ Part IV will focus on the unsettled area of the law regarding the right of the noncompetent nonterminally ill patient to refuse life sustaining medical treatment. Part IV also will provide a comparative survey of the noncompetent nonterminally ill patient's right to refuse medical treatment by focusing on several recent cases which either deny,³¹ severely abridge,³² or preserve³³ the noncompetent patient's rights.

24. Compare *supra* note 14 and accompanying text with *supra* note 15 and accompanying text.

25. See *supra* note 6.

26. See *infra* notes 41-45 and accompanying text.

27. See *infra* notes 46-61 and accompanying text.

28. See *infra* notes 62-74 and accompanying text.

29. The countervailing state interests asserted by most courts are the preservation of life, the prevention of suicide, the maintenance of the ethical integrity of the medical profession, and the protection of third parties. See *infra* notes 78-92 and accompanying text for a complete discussion of the countervailing state interests.

30. In formulating the standards to be used to determine the noncompetent patient's right to refuse medical treatment, the majority of courts have drawn a distinction between noncompetent patients who have been previously competent and noncompetent patients who have never been competent. Moreover, courts have enunciated a further demarcation for the noncompetent patient who has been previously competent based upon the presence or absence of an expressed preference regarding the acceptance or rejection of medical treatment made while the patient was competent. See *infra* notes 106-07 and accompanying text.

31. See *Cruzan v. Harmon*, 760 S.W.2d 408 (Mo. 1988), cert. granted sub nom. *Cruzan v. Director, Mo. Dep't of Health*, 109 S. Ct. 3240 (1989).

32. See *supra* note 10 for examples of methods courts use to abridge the noncompetent patient's right to refuse medical treatment.

33. See, e.g., *Rasmussen v. Fleming*, 154 Ariz. 207, 741 P.2d 674 (1987); *In re Browning*, 543 So. 2d 258 (Fla. Dist. Ct. App. 1989); *In re Peter*, 108 N.J. 365, 529 A.2d

II. THE COMPETENT PATIENT'S RIGHT TO REFUSE LIFE SUSTAINING MEDICAL TREATMENT

A. Definition of Death

The competent patient has a right to refuse life sustaining medical treatment, more commonly known as "the right to die with dignity."³⁴ As the right to refuse medical treatment encompasses the right to refuse treatment even if it ultimately leads to death, a definition of death is essential. The traditional definition of death, known as the "heart-lung" definition, was characterized by termination of the cardiovascular, respiratory, and central nervous systems.³⁵ However, states have replaced the "heart-lung" definition by adopting a uniform standard known as the "brain death" definition, characterized by the complete termination of all functions of the brain, including the brain stem.³⁶

419 (1987); see *infra* notes 145-79 and accompanying text for a complete discussion of these cases.

34. The phrase "the right to die with dignity" was coined to describe the right to refuse life sustaining medical treatment, including treatment which ultimately leads to or results in death. See Note, *The Foundations of the Right to Die*, 90 W. VA. L. REV. 235, 235-36 (1987) [hereinafter *Right to Die*]. Generally, the patient's "right to die" is limited to the right to die naturally. See, e.g., Natural Death Act, CAL. HEALTH & SAFETY CODE § 7195 (West Supp. 1989) (permitting only the natural process of death); Note, *Voluntary Active Euthanasia for the Terminally Ill and the Constitutional Right to Privacy*, 69 CORNELL L. REV. 363, 364 & n.10 (1984).

35. See Note, *Equality for the Elderly Incompetent: A Proposal for Dignified Death*, 39 STAN. L. REV. 689, 694 (1987) [hereinafter *Dignified Death*]; see also *Right to Die*, *supra* note 34, at 236.

36. See *Right to Die*, *supra* note 34, at 236. This definition has been amplified, and it has been posited that brain death occurs when there is an absence of response to external stimuli and internal need, lack of spontaneous breathing and muscular movements, and no elicitable reflexes. Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death, *A Definition of Irreversible Coma*, in ETHICAL ISSUES IN DEATH AND DYING 12 (1978).

Twenty-four states and the District of Columbia determine death either by the heart-lung definition or the brain death definition. See ALASKA STAT. § 09.65.120 (Supp. 1988); ARK. STAT. ANN. § 20-17-101 (1987); CAL. HEALTH & SAFETY CODE § 7180 (Deering Supp. 1989); COLO. REV. STAT. § 12-36-136 (1985); D.C. CODE ANN. § 6-2401 (1989); IDAHO CODE § 54-1819 (1988); IND. CODE ANN. § 1-1-4-3 (Burns 1988); ME. REV. STAT. ANN. tit. 22, § 2811 (Supp. 1988); MD. HEALTH-GEN. CODE ANN. § 5-202(a) (Supp. 1989); MISS. CODE ANN. § 41-36-3 (1981); MONT. CODE ANN. § 50-22-101 (1989); NEV. REV. STAT. § 451.007 (1987); N.H. REV. STAT. ANN. § 141-D:2 (Supp. 1988); N.M. STAT. ANN. § 12-2-4 (1988); OHIO REV. CODE ANN. § 2108.30 (Page's Supp. 1988); OKLA. STAT. ANN. tit. 63, § 3122 (West Supp. 1989); OR. REV. STAT. § 432.300 (1987); PA. STAT. ANN. tit. 35, § 10203 (Purdon 1989); S.C. CODE ANN. § 44-43-460 (Law. Co-op. 1985); TENN. CODE ANN. § 68-3-501 (1987); VT. STAT. ANN. tit. 18, § 5218 (1987); VA. CODE ANN. § 54.1-2972 (1988); W. VA. CODE § 16-10-1 (Supp. 1989); WIS. STAT. ANN. § 146.71 (West 1989); WYO. STAT. § 35-19-101 (Supp. 1988).

Eight states determine death by the brain death definition, in the event that termination of respiration and circulation cannot be established because they are being maintained by artificial means. See ALA. CODE § 22-31-1 (1984); FLA. STAT. ANN. § 382.085 (West 1986); HAW. REV. STAT. § 327C-1 (1985); IOWA CODE ANN. § 702.8 (West 1979); LA. REV. STAT. ANN. § 9:111 (West Supp. 1989); MICH. STAT. ANN. § 14:15 (1021) (Callaghan Supp. 1987); MO. ANN. STAT. § 194.005 (Vernon 1983); TEX. REV. CIV. STAT.

B. *The Bases for the Right to Refuse Life Sustaining Medical Treatment*

The right to refuse life sustaining medical treatment has three bases: (1) the common law right of bodily integrity;³⁷ (2) the constitutional right of privacy;³⁸ and (3) the statutory rights embodied in the natural death acts.³⁹ The patient's right to refuse medical treatment, including treatment which leads to death, has its foundation in one or more of these three bases.⁴⁰

1. The Common Law Right of Bodily Integrity

First, the right to refuse medical treatment is predicated upon the common law right of bodily integrity. The common law right of bodily integrity, which encompasses both the right to be free from non-consensual bodily invasions, as well as the right of self autonomy was first recognized in 1891, in *Union Pacific Railway Co. v. Botsford*.⁴¹ In *Union Pacific Railway*, the Court stated that "[n]o right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law."⁴²

Thereafter, to preserve the patient's right of bodily integrity, the doctrine of informed consent emerged.⁴³ Under this doctrine, the physician must inform the patient of his condition, prognosis, and the

ANN. art. 4447t (Vernon Supp. 1989). One state defines death only by the brain death standard. See ILL. ANN. STAT. ch. 110 1/2, para. 302(b) (Smith-Hurd 1978).

37. See *infra* notes 41-45 and accompanying text.

38. See *infra* notes 46-61 and accompanying text.

39. See *infra* notes 62-74 and accompanying text.

40. Courts often predicate the denial or grant of the right to refuse medical treatment upon one or more of these three bases. See, e.g., *Foody v. Manchester Memorial Hosp.*, 40 Conn. Supp. 127, 132-33, 482 A.2d 713, 717-18 (1984) (right based upon constitutional right of privacy and common law right of bodily integrity); *In re Torres*, 357 N.W.2d 332, 338-39 (Minn. 1984) (right based upon constitutional right of privacy, common law right of bodily integrity, and statutory provision guaranteeing patient's right to refuse medical treatment).

41. 141 U.S. 250 (1891).

42. *Id.* at 251.

43. At common law, medical treatment without the consent of the patient constituted a violation of bodily integrity. See *Schloendorff v. Society of New York Hosp.*, 211 N.Y. 125, 105 N.E. 92 (1914). In *Schloendorff*, the court stated that "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages." *Id.* at 129-30, 105 N.E. at 93 (citation omitted).

risks and benefits of alternative methods of treatment, as well as obtain the patient's consent before the physician may render treatment.⁴⁴ Because informed consent is a requirement for the acceptance or rejection of medical treatment, it is a prerequisite for the refusal of any medical treatment, even that which ultimately leads to death.⁴⁵

2. The Constitutional Right of Privacy

Second, the right to refuse medical treatment is based upon the constitutional right of privacy. In *Griswold v. Connecticut*,⁴⁶ the United States Supreme Court held that a right of privacy existed in the penumbras of the first, third, fourth, and fifth amendments.⁴⁷ Thereafter, in the seminal case of *Roe v. Wade*,⁴⁸ the Court held that the right of privacy was "broad enough to encompass a woman's decision whether or not to terminate her pregnancy."⁴⁹ Subsequent Supreme Court cases have extended the right of privacy to contraception,⁵⁰ procreation,⁵¹ and family relationships.⁵²

Although the Court has stated that the right of privacy is limited,⁵³ it has continued to maintain that fundamental rights are protected by the constitutional right of privacy.⁵⁴ Fundamental rights protected by the Constitution are those rights which are "implicit in the concept of ordered liberty"⁵⁵ or "deeply rooted in this Nation's history and tradition."⁵⁶ As the right to refuse medical treatment is based, in part, upon the long established common law right of bodily integrity,⁵⁷ it may be considered "fundamental" and, therefore, fall within the ambit of the constitutional right of privacy.

44. See *In re Conroy*, 98 N.J. 321, 346-47, 486 A.2d 1209, 1222 (1985); Cantor, *A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity Versus the Preservation of Life*, 26 RUTGERS L. REV. 228, 237 (1973); *Dignified Death*, *supra* note 35, at 699. The doctrine of informed consent requires that the patient be informed of the risks and benefits of all alternatives, including nontreatment.

45. See *Dignified Death*, *supra* note 35, at 699.

46. 381 U.S. 479 (1965).

47. *Griswold* involved the right to use contraception within the marriage relationship. The Court held that such a relationship was "within the zone of privacy created by several fundamental constitutional guarantees." *Id.* at 485.

48. 410 U.S. 113 (1973).

49. *Id.* at 153.

50. *Eisenstadt v. Baird*, 405 U.S. 438 (1972) (contraception for unmarried persons protected under right of privacy).

51. *Doe v. Bolton*, 410 U.S. 179 (1973) (abortion); *Skinner v. Oklahoma ex rel. Williamson*, 316 U.S. 535 (1942) (sterilization).

52. *Moore v. City of East Cleveland*, 431 U.S. 494 (1977) (family living arrangements); *Loving v. Virginia*, 388 U.S. 1 (1967) (interracial marriage).

53. See, e.g., *Roe v. Wade*, 410 U.S. 113, 154 (1973) (right of privacy is not absolute).

54. *Bowers v. Hardwick*, 478 U.S. 186, 191-92, *reh'g denied*, 478 U.S. 1039 (1986).

55. *Palko v. Connecticut*, 302 U.S. 319, 325 (1937).

56. *Moore*, 431 U.S. at 503.

57. See *supra* notes 41-45 and accompanying text.

In the landmark case of *In re Quinlan*,⁵⁸ the New Jersey Supreme Court held that the constitutional right of privacy encompassed a patient's right to refuse medical treatment.⁵⁹ The *Quinlan* court stated that the constitutional right of privacy was "broad enough to encompass a patient's decision to decline medical treatment under certain circumstances, in much the same way as it is broad enough to encompass a woman's decision to terminate pregnancy under certain conditions."⁶⁰ Subsequently, many courts have adopted the reasoning of the *Quinlan* court and have based the right to refuse life sustaining medical treatment, either in part or in whole, upon the constitutional right of privacy.⁶¹

3. The Natural Death Acts

Finally, the right to refuse medical treatment is predicated upon the statutory rights embodied in natural death acts.⁶² These acts pro-

58. 70 N.J. 10, 355 A.2d 647 (1976).

59. *Id.* at 40, 355 A.2d at 663.

60. *Id.* (citing *Roe*, 410 U.S. at 153).

61. See, e.g., *Foody v. Manchester Memorial Hosp.*, 40 Conn. Supp. 127, 132, 482 A.2d 713, 717 (1984); *In re Severns*, 425 A.2d 156, 158-59 (Del. Ch. 1980); *John F. Kennedy Memorial Hosp., Inc., v. Blutworth*, 452 So. 2d 921, 924 (Fla. 1984); *In re Spring*, 380 Mass. 629, 634, 405 N.E.2d 115, 119 (1980); *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 739, 370 N.E.2d 417, 424 (1977); *In re Torres*, 357 N.W.2d 332, 339 (Minn. 1984); *In re Conroy*, 98 N.J. 321, 348, 486 A.2d 1209, 1222-23 (1985); *Leach v. Akron Gen. Medical Center*, 60 Ohio Misc. 1, 7-10 (1980). *But cf. Cruzan v. Harmon*, 760 S.W.2d 408, 417-18 (Mo. 1988), *cert. granted sub nom. Cruzan v. Director, Mo. Dep't of Health*, 109 S. Ct. 3240 (1989).

62. Thirty-seven states and the District of Columbia have enacted natural death acts. See ALA. CODE §§ 22-8A-1 to -10 (1984); ALASKA STAT. §§ 18.12.010-100 (Supp. 1986); ARIZ. REV. STAT. ANN. §§ 36-3201 to -3210 (1986); ARK. STAT. ANN. §§ 20-17-101 to -203 (1987); CAL. HEALTH & SAFETY CODE §§ 7185-7195 (West Supp. 1989); COLO. REV. STAT. §§ 15-18-101 to -113 (Supp. 1986); CONN. GEN. STAT. §§ 19a-570 to -575 (Supp. 1989); DEL. CODE ANN. tit. 16, §§ 2501-2509 (1983); D.C. CODE ANN. §§ 6-2421 to -2430 (1989); FLA. STAT. ANN. §§ 765.01-.15 (West 1986); GA. CODE ANN. §§ 31-32-1 to -12 (1985 & Supp. 1989); HAW. REV. STAT. §§ 327D-1 to -27 (Supp. 1987); IDAHO CODE §§ 39-4501 to 4508 (1985 & Supp. 1989); ILL. ANN. STAT. ch. 110 1/2, para. 701-710 (Smith-Hurd Supp. 1989); IND. CODE ANN. §§ 16-8-11-1 to -22 (Burns Supp. 1989); IOWA CODE ANN. §§ 144A.1-. 11 (West 1989); KAN. STAT. ANN. §§ 65-28,101 to -28,109 (1985); LA. REV. STAT. ANN. §§ 40:1299.58.1-.10 (West Supp. 1989); ME. REV. STAT. ANN. tit. 22, §§ 2921-2931 (Supp. 1988); MD. HEALTH-GEN. CODE ANN. §§ 5-601 to -614 (Supp. 1989); MO. ANN. STAT. §§ 459.010-.055 (Vernon Supp. 1989); MONT. CODE ANN. §§ 50-9-101 to -104, -111, -201 to -206 (1989); NEV. REV. STAT. §§ 449.540-.690 (1987); N.H. REV. STAT. ANN. §§ 137-H:1 to -H:16 (Supp. 1988); N.M. STAT. ANN. §§ 24-7-1 to -10 (1986); N.C. GEN. STAT. ANN. §§ 90-320 to -322 (1985); OKLA. STAT. ANN. tit. 63, §§ 3101-3111 (West Supp. 1989); OR. REV. STAT. §§ 97.050-.090 (1987); S.C. CODE ANN. §§ 44-77-10 to -160 (Law. Co-op. Supp. 1988); TENN. CODE ANN. §§ 32-11-101 to -110 (Supp. 1989); TEX. REV. CIV. STAT. ANN. art. 4590h (Vernon Supp. 1989); UTAH CODE ANN. §§ 75-2-1101 to -1118 (Supp. 1989); VT. STAT. ANN. tit. 18, §§ 5251-5262 (1987); VA. CODE ANN. § 54-1-

vide for the termination of life sustaining procedures in certain circumstances.⁶³ Although the provisions of natural death acts vary from state to state, most contain provisions which define life sustaining procedures, the type of patient to whom the act applies, procedures to execute⁶⁴ and revoke⁶⁵ a living will, and a grant of immunity to health care providers.

A life sustaining procedure typically is any medical procedure or intervention that utilizes mechanical or artificial means to sustain, restore, or supplant a vital function, which serves only to delay the moment of death, or where death would be imminent regardless of the application of such measures.⁶⁶ Many states limit the definition of life sustaining procedure by excluding the administration of medication or any medical procedure designed to alleviate pain.⁶⁷ States further circumscribe the definition by excluding the administration of nutrition and hydration.⁶⁸

Almost all of the natural death acts provide that the provisions of the act apply only to a "qualified patient." To be considered a qualified patient, the patient must comply with two elements: (1) a living will must be executed by the patient; and (2) the patient must be in a terminal condition.⁶⁹ Consequently, the natural death acts provide a

2984 (Supp. 1989); WASH. REV. CODE ANN. §§ 70.122.010-.905 (West Supp. 1989); W. VA. CODE §§ 16-30-1 to -10 (1985); WIS. STAT. ANN. §§ 154.01-.15 (West 1989); WYO. STAT. §§ 35-22-101 to -109 (1988).

63. Natural death acts only apply to patients who are in a terminal condition. See *supra* note 21 and accompanying text for discussion of terminal condition.

64. Generally the requirements necessary for the execution of a testamentary will also apply to the execution of a living will. See *Right To Die, supra* note 34, at 248-49.

65. Revocation of a living will can occur by the destruction of the will, written revocation, or an oral expression by the declarant which demonstrates an intent to revoke the will. Revocation may only be accomplished by the declarant or a person acting on behalf of the declarant. See *supra* note 62 for statutes; see also *Right To Die, supra* note 34, at 249.

66. See, e.g., ARIZ. REV. STAT. ANN. § 36-3201 (1986); CAL. HEALTH & SAFETY CODE § 7187(c) (West Supp. 1989); TEX. REV. CIV. STAT. ANN. art. 4590h (Vernon Supp. 1989).

67. See, e.g., ARIZ. REV. STAT. ANN. § 36-3201 (1986) (provide comfort or care); CAL. HEALTH & SAFETY CODE § 7187(c) (West Supp. 1989) (alleviate pain); COLO. REV. STAT. § 15-18-103(7) (Supp. 1987) (provide comfort or alleviate pain); IND. CODE ANN. § 16-8-11-4 (Burns Supp. 1989) (provide comfort, care, or alleviate pain); IOWA CODE ANN. § 144A.2 (West 1989) (provide comfort, care, or alleviate pain); N.H. REV. STAT. ANN. § 137-H:2 (Supp. 1988) (provide comfort, care, or alleviate pain).

68. See, e.g., ARIZ. REV. STAT. ANN. § 36-3201(4) (1986) (food or fluids); COLO. REV. STAT. § 15-18-103(7) (Supp. 1987) (nourishment); HAW. REV. STAT. § 327D-2 (Supp. 1986) (fluids and nourishment); IOWA CODE ANN. § 144A.2(5) (West 1989) (sustenance); ME. REV. STAT. ANN. tit. 22, § 2921(4) (Supp. 1988) (nutrition and hydration); N.H. REV. STAT. ANN. § 137-H:2(II) (Supp. 1988) (sustenance); OKLA. STAT. ANN. tit. 63, § 63-3102(4) (West Supp. 1989) (nourishment and hydration); S.C. CODE ANN. § 44-77-20(2) (Law. Co-op. Supp. 1988) (nutrition and hydration); UTAH CODE ANN. § 75-2-11-03(6)(b) (Supp. 1989) (sustenance). Nevertheless, two states specify that nutrition or hydration fall within the ambit of life sustaining procedures. See ALASKA STAT. § 18.12.040(b) (Supp. 1986); TENN. CODE ANN. § 32-11-103(5) (Supp. 1989).

69. See *supra* note 62 for statutes.

limited foundation for the right to refuse medical treatment as they only pertain to patients who are in a terminal condition. Terminal condition frequently is defined as having these elements: an incurable or irreversible condition resulting from injury, disease, or illness with either no chance of recovery, or death will occur regardless of life sustaining measures, and death is imminent or only delayed by the use of life sustaining measures.⁷⁰

Most natural death acts also contain provisions for the execution and revocation of a "living will," which is a written directive signed by the patient directing that life sustaining procedures be withheld or withdrawn in the event the patient is in a terminal condition.⁷¹ If the patient becomes incompetent or is otherwise unable to make decisions regarding life sustaining procedures, the living will is deemed to be the final expression of the patient's right to refuse medical

70. See *Right to Die*, *supra* note 34, at 247-48.

71. The California Natural Death Act directive is illustrative of the type of directive necessary for the living will authorized by natural death acts.

DIRECTIVE TO PHYSICIANS

Directive made this _____ day of _____ (month, year).

I _____, being of sound mind, willfully, and voluntarily make known my desire that my life shall not be artificially prolonged under the circumstances set forth below, do hereby declare:

1. If at any time I should have an incurable injury, disease, or illness certified to be a terminal condition by two physicians, and where the application of life-sustaining procedures would serve only to artificially prolong the moment of my death and where my physician determines that my death is imminent whether or not life-sustaining procedures are utilized, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally.
2. In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this directive shall be honored by my family and physician(s) as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.
3. If I have been diagnosed as pregnant and that diagnosis is known to my physician, this directive shall have no force or effect during the course of my pregnancy.
4. I have been diagnosed and notified at least 14 days ago as having a terminal condition by _____, M.D., whose address is _____, and whose telephone number is _____. I understand that if I have not filled in the physician's name and address, it shall be presumed that I did not have a terminal condition when I made out this directive.
5. This directive shall have no force or effect five years from the date filled in above.
6. I understand the full import of this directive and I am emotionally and mentally competent to make this directive.

Signed _____

City, County and State of Residence _____

treatment.⁷²

In addition, all of the natural death acts grant immunity⁷³ from civil liability or criminal prosecution to the physician or health care provider in the event that life sustaining procedures are withdrawn or withheld from a qualified patient. Other provisions which may be included in the natural death acts are provisions regarding insurance, penalties for withholding or forging a living will or revocation, and provisions stating that the withdrawal or withholding of life sustaining procedures does not constitute suicide or homicide.⁷⁴

C. *The Countervailing State Interests*

Although the right to refuse life sustaining medical treatment is predicated upon the constitutional right of privacy, the right of privacy is not absolute.⁷⁵ The patient's right of privacy must be balanced against countervailing state interests.⁷⁶ However, the countervailing state interest must be compelling in nature to override the patient's right to refuse life sustaining medical treatment.⁷⁷ Consequently, states have identified four interests which may supersede individual privacy rights: (1) the preservation of life; (2) the prevention of suicide; (3) the preservation of the ethical integrity of the medical profession; and (4) the protection of third parties.

1. The Preservation of Life

First, the state has an interest in the preservation of life.⁷⁸ This

The declarant has been personally known to me and I believe him or her to be of sound mind.

Witness _____

Witness _____

CAL. HEALTH & SAFETY CODE § 7188 (West Supp. 1989).

72. However, all of the natural death acts provide that at all times the desires of the declarant supersede the living will. *See supra* note 62 for statutes.

73. *See id.* Immunity is granted to the health care provider as long as the health care provider acts in good faith, *e.g.*, ARIZ. REV. STAT. ANN. § 36-3205(c) (1986) (good faith), in accordance with reasonable medical standards, *e.g.*, ARK. STAT. ANN. § 20-17-208(b) (1986) (reasonable medical standards), or both, *e.g.*, N.H. REV. STAT. ANN. § 137-H:9 (Supp. 1988) (good faith and reasonable medical standards).

74. *See supra* note 62 for statutes.

75. *See, e.g.*, *Roe v. Wade*, 410 U.S. 113, 154 (1973) (right of privacy in abortion cases balanced against important state interests of safeguarding health, maintaining medical standards, and protecting potential life).

76. *See supra* note 75 and *infra* notes 78-92 and accompanying text for a discussion of countervailing state interests.

77. The state must assert a compelling state interest because the right to refuse life sustaining medical treatment is predicated upon the constitutional right of privacy which is a fundamental right guaranteed by the constitution. *See supra* note 75 and accompanying text.

78. *See Foody v. Manchester Memorial Hosp.*, 40 Conn. Supp. 127, 133, 482 A.2d

may encompass interests in the prolongation of life as well as the sanctity of life.⁷⁹ Although the state interest in the preservation of life may seem compelling, it must be balanced against the patient's right to refuse medical treatment. Thus, the state's interest must be counterbalanced against the patient's prognosis, the degree of bodily invasion necessitated by the treatment, and the probability that the patient will return to a cognitive existence.⁸⁰ Moreover, the interest of the state "weakens and the individual's right to privacy grows as the degree of bodily invasion increases and the prognosis dims. Ultimately there comes a point at which the individual's rights overcome the State interest."⁸¹

2. The Prevention of Suicide

Second, the state has an interest in the prevention of suicide.⁸² This interest does not necessarily prohibit the patient's right to refuse medical treatment, as the rejection of medical treatment does not constitute suicide when the patient lacks the specific intent to die.⁸³ Moreover, as death often results from natural causes, the pa-

713, 718 (1984); *Satz v. Perlmutter*, 362 So. 2d 160, 162 (Fla. Dist. Ct. App. 1978), *approved*, 379 So. 2d 359 (Fla. 1980); *In re Spring*, 380 Mass. 629, 641, 405 N.E.2d 115, 123 (1980); *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 741, 370 N.E.2d 417, 425 (1977); *In re Conroy*, 98 N.J. 321, 348, 486 A.2d 1209, 1223 (1985); *In re Storar*, 52 N.Y.2d 363, 377, 420 N.E.2d 64, 71, 438 N.Y.S.2d 266, 273 (1981); *Leach v. Akron Gen. Medical Center*, 68 Ohio Misc. 1 (1980).

79. *Cruzan v. Harmon*, 760 S.W.2d 408, 419 (Mo. 1988), *cert. granted sub nom. Cruzan v. Director, Mo. Dep't of Health*, 109 S. Ct. 3240 (1989). In *Cruzan*, the Missouri Supreme Court stated that the "state's interest in life embraces two separate concerns: an interest in the prolongation of the life . . . and an interest in the sanctity of life itself." *Id.* Moreover, the court indicated that the "state's concerns with the sanctity of life rests on the principle that life is precious and worthy of preservation without regard to its quality." *Id.*

80. *In re Quinlan*, 70 N.J. 10, 40, 355 A.2d 647, 664, *cert. denied*, 429 U.S. 922 (1976).

81. *Id.* at 41, 355 A.2d at 664.

82. Some courts indicate that the state interest in the prevention of suicide does not necessarily override the patient's right to forego life sustaining medical treatment. *See, e.g., In re Hier*, 18 Mass. App. Ct. 200, 210, 464 N.E.2d 959, 965 (1984); *Saunders v. State*, 129 Misc. 2d 45, 50, 492 N.Y.S.2d 510, 514 (1985); *In re Lydia E. Hall Hosp.*, 116 Misc. 2d 477, 486, 455 N.Y.S.2d 706, 711 (1982). In addition, most of the natural death acts indicate that the withholding or withdrawal of life sustaining procedures does not constitute suicide. *See, e.g., CAL. HEALTH & SAFETY CODE* § 7192(a) (West Supp. 1989) ("The withholding or withdrawal of life-sustaining procedures from a qualified patient . . . shall not, for any purpose, constitute a suicide.").

83. *Foody v. Manchester Memorial Hosp.*, 40 Conn. Supp. 127, 482 A.2d 713 (1984) (court allowed removal of respirator from semi-comatose patient because it did not contravene state interest in prevention of suicide since patient lacked intent to die); *Leach v. Akron Gen. Medical Center*, 68 Ohio Misc. 1 (1980) (state interest in prevention of suicide failed to override patient's right to refuse medical treatment because re-

tient does not initiate death by the removal of medical treatment, but merely allows the process of death to continue unabated.⁸⁴ Furthermore, the state's interest in the prevention of suicide is the prevention of self-destruction, not the prohibition of self-determination as exercised through a decision to forego life sustaining medical treatment.⁸⁵

3. The Preservation of the Ethical Integrity of the Medical Profession

Third, the state has an interest in the preservation of the ethical integrity of the medical profession.⁸⁶ Ethical integrity is not necessarily compromised when the patient's right to refuse medical treatment is upheld as medical ethics do not always require medical treatment or intervention.⁸⁷ The patient's rejection of medical treatment may even be consistent with medical ethics when "physicians distinguish between curing the ill and comforting and easing the dy-

removal of respirator only demonstrates intent to forego treatment not specific intent to die). See generally Comment, *Suicidal Competence and the Patient's Right to Refuse Lifesaving Treatment*, 75 CALIF. L. REV. 707 (1987).

84. See *Foody*, 40 Conn. Supp. at 137, 482 A.2d at 720 (death resulted from natural causes; therefore, patient did not initiate dying process); Superintendent of Belchertown State School v. Saikewicz, 373 Mass. 728, 743 n.11, 370 N.E.2d 417, 426, n.11 (1977) (natural causes produced death; therefore, patient did not set death process in motion); *In re Conroy*, 98 N.J. 321, 351, 486 A.2d 1209, 1224 (1985) (death resulted from underlying organic disease).

85. *Saikewicz*, 373 Mass. at 743, 370 N.E.2d at 426; *Conroy*, 98 N.J. at 350-51, 486 A.2d at 1224.

86. See, e.g., *Foody*, 40 Conn. Supp. at 135-37, 482 A.2d at 719; *Leach*, 68 Ohio Misc. at 10.

87. The American Medical Association has stated that it is not unethical to discontinue life sustaining medical procedures in certain circumstances:

For humane reasons, with informed consent, a physician may do what is medically necessary to alleviate severe pain, or cease or omit treatment to permit a terminally ill patient whose death is imminent to die. However, he should not intentionally cause death. In deciding whether the administration of potentially life-prolonging medical treatment is in the best interest of the patient who is incompetent to act in his own behalf, the physician should determine what the possibility is for extending life under humane and comfortable conditions and what are the prior expressed wishes of the patient and attitudes of the family or those who have responsibility for the custody of the patient.

Even if death is not imminent but a patient's coma is beyond doubt irreversible and there are adequate safeguards to confirm the accuracy of the diagnosis and with the concurrence of the those who have responsibility for the care of the patient, *it is not unethical to discontinue all means of life prolonging medical treatment.*

Life prolonging medical treatment includes medication and artificially or technologically supplied respiration, nutrition or hydration. In treating a terminally ill or irreversibly comatose patient, the physician should determine whether the benefits of treatment outweigh its burdens. At all times, the dignity of the patient should be maintained.

AMA Council on Ethical and Judicial Affairs, statement March 15, 1986 (emphasis added) [hereinafter AMA Statement].

ing"⁸⁸ and render treatment in accordance with this principle. Furthermore, the right of the patient should be upheld and may supersede the decision of the physician if a conflict arises between the patient's decision and the medical profession.⁸⁹

4. The Protection of Third Parties

Finally, the state has an interest in the protection of third parties.⁹⁰ The primary interest which the state seeks to safeguard is the protection of minor children from emotional and financial harm.⁹¹ However, if provision has been made for the care of minor children, the patient's right to refuse medical treatment may override the countervailing state interest in the protection of third parties.⁹²

III. THE NONCOMPETENT TERMINALLY ILL PATIENT'S RIGHT TO REFUSE LIFE SUSTAINING MEDICAL TREATMENT

A. *The Recognition of the Right to Refuse Medical Treatment*

The noncompetent terminally ill patient generally is accorded a right to refuse life sustaining medical treatment that is similar to the right granted to the competent patient.⁹³ However, this right may vary depending upon whether the noncompetent patient has been previously competent.⁹⁴

The noncompetent patient is defined as one who is unable to make

88. *In re Quinlan*, 70 N.J. 10, 47, 355 A.2d 647, 667 (1976).

89. *See Rasmussen v. Fleming*, 154 Ariz. 207, 217, 741 P.2d 674, 684 (1987); *Conroy*, 98 N.J. at 352-53, 486 A.2d at 1225; *see also* AMA Statement, *supra* note 87. The AMA has stated that "[t]he social commitment of the physician is to sustain life and relieve suffering. Where the performance of one duty conflicts with the other, the choice of the patient, or his family or legal representative if the patient is incompetent to act in his own behalf, should prevail." *Id.*

90. *John F. Kennedy Memorial Hosp., Inc. v. Bludworth*, 452 So. 2d 921, 924 (Fla. 1984); *Saunders v. State*, 129 Misc. 2d 45, 50, 492 N.Y.S.2d 510, 514 (1985); *In re Lydia E. Hall Hosp.*, 116 Misc. 2d 477, 486, 455 N.Y.S.2d 706, 711 (1982).

91. *See Foody v. Manchester Memorial Hosp.*, 40 Conn. Supp. 127, 137-38, 482 A.2d 713, 720 (1984); *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 742-43, 370 N.E.2d 417, 426 (1977).

92. *In re Osborne*, 294 A.2d 372, 374 (D.C. 1972).

93. *See supra* note 20 and accompanying text.

94. If the noncompetent patient has been previously competent, the majority of courts apply the substituted judgment test if clear and convincing evidence exists of a past expressed preference regarding acceptance or rejection of life sustaining medical treatment made while the patient was competent. *See infra* notes 111-17 and accompanying text for discussion of the substituted judgment test. The surrogate decisionmaker, through the substituted judgment test, seeks to determine the decision the noncompetent patient would make if the patient were competent. In the alternative, the best interests test is used to determine the patient's right based upon the objective

medical decisions, including those decisions regarding the withdrawal or withholding of life sustaining medical treatment.⁹⁵ Because of this inability, the noncompetent patient's right is preserved and exercised through a surrogate decisionmaker.⁹⁶ The decisionmaker's authority and the standards used to guide the exercise of the noncompetent patient's right depend upon the nature of the patient's noncompetency.⁹⁷

B. *The Establishment of the Right to Refuse Medical Treatment*

The noncompetent patient's right to refuse life sustaining medical treatment was first established in the landmark case of *In re Quinlan*.⁹⁸ In *Quinlan*, the New Jersey Supreme Court upheld the right of Karen Ann Quinlan, a patient in a noncognitive, vegetative state, to refuse life sustaining medical treatment based upon the constitutional right of privacy as exercised on her behalf by her guardian and family.⁹⁹ The court stated that the right to terminate a noncognitive vegetative existence was an important incident of the right of privacy, and therefore, the right could not be destroyed "solely on the basis that [a] condition prevents [a] conscious exercise of the choice."¹⁰⁰ Thus, the court allowed Karen Quinlan's right of privacy to be exercised on her behalf by her guardian, because it was "[t]he

best interests of the patient. See *infra* notes 118-21 and accompanying text for a discussion of the best interests test.

However, if the noncompetent patient has never been competent, courts are more reluctant to grant the noncompetent patient the right to refuse medical treatment. See *In re Storar*, 52 N.Y.2d 363, 378-81, 420 N.E.2d 64, 71-73, 438 N.Y.S.2d 266, 273-75 (1981) (substituted judgment test cannot apply to noncompetent patient who has never been competent). Nevertheless, at least one court has applied the substituted judgment test to a noncompetent patient who had not been previously competent. See *Saikewicz*, 373 Mass. at 728, 370 N.E.2d at 417; see also *infra* note 117 and accompanying text.

95. See *infra* notes 128-30 and accompanying text. As used in this article, noncompetency refers to the inability to make decisions and it is "not a medical or a psychiatric diagnostic category; it rests on a judgment of the type that an informed layperson might make—that a patient lacks sufficient ability to understand a situation and to make a choice in light of that understanding." PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, DECIDING TO FOREGO LIFE-SUSTAINING TREATMENT: A REPORT ON THE ETHICAL, MEDICAL AND LEGAL ISSUES IN TREATMENT DECISIONS 123 (1983) (footnote omitted) [hereinafter PRESIDENT'S REPORT]. Furthermore, noncompetency resulting from the lack of capacity to make decisions is characterized by the inability to understand information necessary to the decision; the inability to weigh and decide upon alternatives in accordance with personal values; and the inability to communicate with others, especially those responsible for the care of the patient. See THE HASTINGS CENTER, GUIDELINES ON THE TERMINATION OF LIFE-SUSTAINING TREATMENT AND THE CARE OF THE DYING 131 (1987).

96. See *supra* note 8.

97. See *infra* notes 106-21 and accompanying text.

98. 70 N.J. 10, 355 A.2d 647 (1976).

99. *Id.* at 41-42, 355 A.2d at 664.

100. *Id.*

only practical way to prevent destruction of the right."¹⁰¹ Subsequent cases have followed *Quinlan* and preserved the noncompetent patient's right to refuse life sustaining medical treatment as exercised by a surrogate decisionmaker.¹⁰²

C. *The Determination of the Right to Refuse Medical Treatment*

Since the majority of courts¹⁰³ grant the noncompetent terminally ill patient a right to refuse medical treatment which is similar to the right accorded to the competent patient, no distinction exists based upon the noncompetent status of the patient. Consequently, the noncompetent patient's right to refuse medical treatment is determined in the same way as the competent patient's right. Thus, courts balance the noncompetent patient's right, based upon the common law right of bodily integrity, the constitutional right of privacy and the statutory rights embodied in the natural death acts,¹⁰⁴ against the countervailing state interests.¹⁰⁵

Although the noncompetent terminally ill patient's right to refuse medical treatment is preserved because it is exercised by a surrogate decisionmaker, the determination of this right often depends upon

101. *Id.* The court stated that if the guardian elected to exercise the right of privacy on behalf of the patient, "this decision should be accepted by a society the overwhelming majority of whose members would, we think, in similar circumstances, exercise such a choice in the same way for themselves or for those closest to them."
Id.

102. *See, e.g.,* *Foody v. Manchester Memorial Hosp.*, 40 Conn. Supp. 127, 133, 482 A.2d 713, 718 (1984) ("To deny the exercise because the patient is unconscious or incompetent would be to deny the right. It is incumbent upon the state to afford an incompetent the same panoply of rights and choices it recognizes in competent persons.") (citations omitted); *Severns v. Wilmington Medical Center*, 421 A.2d 1334, 1347 (Del. 1980) ("[A court] may recognize the right of a guardian . . . to vicariously assert the constitutional right of a comatose ward to accept medical care or to refuse it."); *In re Spring*, 380 Mass. 629, 634, 405 N.E.2d 115, 119 (1980) ("[A] competent person has a general right to refuse medical treatment in appropriate circumstances The same right is also extended to an incompetent person to be exercised through a 'substituted judgment' on his behalf."); *In re Conroy*, 98 N.J. 321, 359-60, 486 A.2d 1209, 1229 (1985) ("The right of an adult who . . . was once competent, to determine the course of her medical treatment remains intact even when she is no longer able to assert that right or to appreciate its effectation."); *Leach v. Akron Gen. Medical Center*, 68 Ohio Misc. 1, 9 (1980) ("[I]t would be difficult to deny the existence of the right of a terminally, incurably ill and permanently semi-comatose person to decide his or her own treatment.").

103. *See supra* notes 93-94 and accompanying text.

104. *See supra* notes 37-74 and accompanying text for a discussion of the three bases upon which the right to refuse medical treatment is predicated.

105. *See supra* notes 75-92 and accompanying text for a discussion of the countervailing state interests.

the noncompetent status of the patient. Some courts have established a demarcation between patients who are presently noncompetent but have been previously competent and those patients who are currently noncompetent but have never been competent.¹⁰⁶ In addition, some courts have enunciated a further demarcation among noncompetent patients who previously have been competent, based upon the presence or absence of a past expressed preference regarding the acceptance or rejection of medical treatment made by the patient when competent.¹⁰⁷

D. *The Exercise of the Right to Refuse Medical Treatment*

Courts have used two tests¹⁰⁸ to implement the noncompetent patient's right to refuse life sustaining medical treatment: (1) a subjective test based upon the "substituted judgment" of the patient's family or guardian;¹⁰⁹ and (2) an objective test which focuses on the

106. See *supra* note 94 and accompanying text.

107. A past expressed intent regarding medical treatment, whether oral or written, is determinative of the patient's decision to forego treatment. See *Right to Die, supra* note 34, at 267. However, many courts require a showing of clear and convincing evidence of past intention to support a decision to terminate treatment. See, e.g., *In re Browning*, 543 So. 2d 258, 273 (Fla. Dist. Ct. App. 1989); *In re Peter*, 108 N.J. 365, 384-85, 529 A.2d 419, 429 (1987). See generally *In re Barry*, 445 So. 2d 365, 372 (1984).

The *Browning* court defined clear and convincing evidence in the following manner:

[C]lear and convincing evidence requires that the evidence must be found to be credible; the facts to which the witnesses testify must be distinctly remembered; the testimony must be precise and explicit and the witnesses must be lacking in confusion as to the facts in issue. The evidence must be of such weight that it produces in the mind of the trier of fact a firm belief or conviction, without hesitancy, as to the truth of the allegations sought to be established.

Browning, 543 So. 2d at 273 (quoting *Slomowitz v. Walker*, 429 So. 2d 797, 800 (Fla. Dist. Ct. App. 1983)). The *Browning* court further held that "[i]t is possible for the evidence in such a case to be clear and convincing, even though some evidence may be inconsistent. Likewise, it is possible for the evidence to be uncontroverted and yet not be clear and convincing." *Id.* (citation omitted).

108. Some courts employ a combination of the subjective substituted judgment test and the objective best interests test to determine the right of the noncompetent patient to refuse life sustaining medical treatment. See, e.g., *Foody v. Manchester Memorial Hosp.*, 40 Conn. Supp. 127, 138-39, 482 A.2d 713, 720-21 (1984) (subjective substituted judgment test is primary test used, but if evidence of patient's intent is absent, objective best interests test is applied); *In re Conroy*, 98 N.J. 321, 360-68, 486 A.2d 1209, 1229-33 (1985) ("subjective," "limited-objective," and "pure-objective" tests used).

Moreover, courts may determine the applicable hierarchy of tests to be employed depending upon the degree of evidence present regarding the patient's expressed preference for refusal of medical treatment. See *Peter*, 108 N.J. at 384-85, 529 A.2d at 429 (if clear and convincing evidence is present, *Conroy* subjective test is used, but if clear and convincing evidence is absent, substituted judgment test is applied) (for an explanation of the *Conroy* subjective test, see *infra* note 167).

109. See *John F. Kennedy Memorial Hosp., Inc. v. Blutworth*, 452 So. 2d 921, 926 (Fla. 1984); *In re Spring*, 380 Mass. 629, 634, 405 N.E.2d 115, 119 (1980); *In re Hier*, 18 Mass. App. Ct. 200, 207, 464 N.E.2d 959, 963-64 (1984). But cf. *Weber, Substituted Judgment Doctrine: A Critical Analysis*, 1 ISSUES IN L. & MED. 131 (1985) ("[T]he substi-

patient's "best interests."¹¹⁰

1. The Substituted Judgment Test

The substituted judgment test is the most common standard¹¹¹ used to implement the noncompetent patient's right to refuse medical treatment. Substituted judgment is a subjective standard¹¹² which requires a surrogate decisionmaker to act as the noncompetent patient would act under the same circumstances if the patient were competent.¹¹³ The substituted judgment test generally is used in the case of the noncompetent patient who has been previously competent, when clear and convincing evidence exists that the noncompetent patient would refuse life sustaining medical treatment if the patient had the ability to make the decision.¹¹⁴

Thus, when the noncompetent patient has been previously competent, the test often is based upon the patient's past expressed preference regarding life sustaining medical treatment.¹¹⁵ However, some

tuted judgment standard . . . suffers from theoretical incoherence and practical unworkability, and facilitates the exploitation and abuse of incompetent individuals.").

110. See, e.g., *Rasmussen v. Fleming*, 154 Ariz. 207, 221-22, 741 P.2d 674, 688-89 (1987); *In re Torres*, 357 N.W.2d 332, 338-39 (Minn. 1984).

111. See *Dignified Death*, *supra* note 35, at 708 ("The most commonly applied standard is substituted judgment.").

112. The substituted judgment test is regarded as a subjective test because the surrogate decisionmaker must make the decision that the noncompetent patient would have made if competent, even if this conflicts with or is different from the choice the surrogate would make. See *In re Browning*, 543 So. 2d 258, 272-73 (Fla. Dist. Ct. App. 1989). Thus, the decisionmaker does not take into consideration any objective factors, and the decision is based upon the patient's desires. *Id.*

113. See cases cited *supra* note 109; see also PRESIDENT'S REPORT, *supra* note 95, at 132 (noting that the decisionmaker "attempt[s] to reach the decision that the incapacitated person would make if he or she were able to choose") (footnote omitted).

The substituted judgment standard was first recognized in *In re Quinlan*. The *Quinlan* court stated that:

[The right to refuse medical treatment] should not be discarded solely on the basis that her condition prevents her conscious exercise of the choice. The only practical way to prevent destruction of the right is to permit the guardian and family . . . to render their best judgment . . . as to whether she would exercise it in these circumstances. If their conclusion is in the affirmative this decision should be accepted by a society the overwhelming majority of whose members would, we think, in similar circumstances, exercise such a choice in the same way for themselves or for those closest to them.

In re Quinlan, 70 N.J. 10, 41-42, 355 A.2d 647, 664, *cert. denied*, 429 U.S. 922 (1976).

114. See, e.g., *Browning*, 543 So. 2d at 272-73 (surrogate decisionmaker must consider the following factors in determining the decision the patient would have made: presence of a living will, verbal statements made when the patient was competent, patient's religious beliefs, and character evidence from family members and friends of the patient).

115. See *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 1021, 195 Cal. Rptr. 484,

courts have applied the substituted judgment test even when there was no clear and convincing evidence of a past expressed intention regarding medical treatment.¹¹⁶ In addition, at least one court has applied the substituted judgment test to a noncompetent patient who was never competent or able to express a preference regarding life sustaining medical treatment.¹¹⁷

2. The "Best Interests" Test

The second test used to implement the noncompetent patient's right to refuse life sustaining medical treatment focuses on the objective "best interests"¹¹⁸ of the patient. The best interests test is used

493 (1983); *In re Severns*, 425 A.2d 156, 159 (Del. Ch. 1980); *John F. Kennedy Memorial Hosp., Inc. v. Blutworth*, 452 So. 2d 921, 926 (Fla. 1984); *Saunders v. State*, 129 Misc. 2d 45, 54, 492 N.Y.S.2d 510, 517 (1985); *In re Lydia E. Hall Hosp.*, 116 Misc. 2d 477, 487-88, 455 N.Y.S.2d 706, 712 (1982); *Leach v. Akron Gen. Medical Center*, 68 Ohio Misc. 1, 7-8 (1980).

116. See *Foody v. Manchester Memorial Hosp.*, 40 Conn. Supp. 127, 140, 482 A.2d 713, 720-21 (1984) (no expressed intent by patient, but court applied substituted judgment test and authorized termination of life sustaining measures); *In re Spring*, 380 Mass. 629, 640, 405 N.E.2d 115, 122 (1980) (court applied substituted judgment test in absence of an expressed intent by patient, based on opinion of patient's wife and son that patient would have refused medical treatment if competent).

117. *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E.2d 417 (1977). In *Saikewicz*, the patient, Joseph Saikewicz, was severely mentally retarded and had been diagnosed with acute leukemia. *Id.* at 729, 370 N.E.2d at 419-20. Other than the leukemia, Saikewicz was in good health, although he had an I.Q. of 10 and a mental age of two years and eight months. *Id.* at 731, 370 N.E.2d at 420. Eventually, the court appointed a guardian ad litem, who recommended that Saikewicz not undergo chemotherapy for treatment of the leukemia due to the adverse side effects. *Id.* at 729-30, 370 N.E.2d at 419.

The court agreed with the guardian ad litem's decision and applied the substituted judgment test to determine whether Saikewicz should receive the treatment. The court stated that the substituted judgment test was "subjective in nature—that is, the goal is to determine with as much accuracy as possible the wants and needs of the individual involved." *Id.* at 750, 370 N.E.2d at 430 (footnote omitted). The court proceeded to apply the substituted judgment test and found that if Saikewicz had been competent, he would have decided to forego the treatment. *Id.* at 754-55, 370 N.E.2d at 431-32.

In applying the substituted judgment test, the court balanced the factors favoring chemotherapy, *i.e.*, most patients choose chemotherapy, and the possibility of prolonging life, against the factors militating against chemotherapy, *i.e.*, the patient's age, the potential side effects, the low possibility of remission, the certainty that the treatment would produce immediate suffering, the patient's lack of ability to cooperate in the treatment, and the resultant quality of life if treatment caused remission. *Id.* at 753-54, 370 N.E.2d at 431-32. *But cf. In re Storar*, 52 N.Y.2d 363, 380-82, 420 N.E.2d 64, 72-73, 438 N.Y.S.2d 266, 274-76, *cert. denied*, 454 U.S. 858 (1981) (substituted judgment test cannot be used to determine if life sustaining medical treatment can be withdrawn from a noncompetent patient who has never been competent because it is not possible to determine what the patient's wishes would have been if competent).

118. *Rasmussen v. Fleming*, 154 Ariz. 207, 221-22, 741 P.2d 674, 688-89 (1987); *In re Torres*, 357 N.W.2d 332, 338 (Minn. 1984). The best interests standard is considered to be the traditional approach used to determine the right of the noncompetent patient and contains a "presumption in favor of life, health, and best interests of the patient." Clarke, *The Choice to Refuse or Withhold Medical Treatment: The Emerging Technol-*

when evidence of a patient's past expressed preference regarding life sustaining medical treatment is absent.¹¹⁹ Under this test, the court or guardian seeks to act in the best interests of the patient, based upon such objective factors as the relief from physical suffering, the probability of restoration of functioning, and the quality and duration of the patient's life.¹²⁰ The court also may consider whether the benefits received by the patient from the treatment outweigh the burdens.¹²¹

It is more or less settled that the noncompetent terminally ill patient has the right to refuse life sustaining medical treatment, although a wide variety and combination of standards may be employed to implement this right. Courts seem particularly willing to afford the noncompetent terminally ill patient this right, based upon the substituted judgment test or the best interests test, when the patient is in a terminal condition and the prognosis is dim.¹²² However, as will be discussed in Part IV, courts are far less willing to grant the noncompetent nonterminally ill¹²³ patient the right to refuse medical treatment, and in some cases may entirely abridge the right merely because the patient is not in a terminal condition.¹²⁴

ogy and Medical-Ethical Consensus, 13 CREIGHTON L. REV. 795, 824 (1980). Thus, commentators have suggested that because the best interests test contains a presumption in favor of life, it encompasses the administration of procedures necessary to preserve life, and thereby precludes the alternative of nontreatment or the withholding of life sustaining measures. *See id.*; Weber, *supra* note 109, at 133-34 ("[I]t is far from intuitive that death can be in one's best interest."). *But cf.* PRESIDENT'S REPORT, *supra* note 95, at 181-83 (continuance of life sustaining medical treatment may not serve best interests of patient).

119. *See Rasmussen*, 154 Ariz. at 222, 741 P.2d at 689 (when reliable evidence of patient's intent is absent, best interests test is used); *see also* PRESIDENT'S REPORT, *supra* note 95, at 136 ("[D]ecisionmaking for incapacitated patients should be guided by the principle of substituted judgment When a patient's likely decision is unknown, however, a surrogate decisionmaker should use the best interests standard").

120. *Rasmussen*, 154 Ariz. at 222, 741 P.2d at 689; *see* PRESIDENT'S REPORT, *supra* note 95, at 135.

121. *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 1016-19, 195 Cal. Rptr. 484, 490-91 (1983) (chance of improvement weighed against pain or intrusion involved in the treatment).

122. *See supra* note 81 and accompanying text.

123. *See infra* notes 141-89 and accompanying text.

124. *Cruzan v. Harmon*, 760 S.W.2d 408 (Mo. 1988), *cert. granted sub nom. Cruzan v. Director, Mo. Dep't of Health*, 109 S. Ct. 3240 (1989); *see also infra* notes 180-89 and accompanying text.

IV. THE NONCOMPETENT NONTERMINALLY ILL PATIENT'S RIGHT TO REFUSE LIFE SUSTAINING MEDICAL TREATMENT

Although the noncompetent terminally ill patient generally has the right to refuse life sustaining medical treatment,¹²⁵ the law is less well settled as applied to the noncompetent nonterminally ill patient. No definitive standard exists to determine the right of the noncompetent nonterminally ill patient to refuse medical treatment.¹²⁶ Moreover, although the tests employed to implement the right appear to be clear, there is a wide variety of judicial interpretation and analyses, and in addition, the tests are often the result of hybridization and combination.¹²⁷

A. Definitions: Noncompetency and Nonterminal Illness

Noncompetency usually is defined as the inability to make independent decisions or to exercise personal autonomy, including the absence of an ability to make decisions regarding the rejection or acceptance of life sustaining medical treatment.¹²⁸ Noncompetency typically is determined in a judicial proceeding,¹²⁹ whereby the court appoints a guardian for the noncompetent patient if it determines that the patient is unable to provide for his own care or to manage his affairs.¹³⁰

The nonterminally ill patient is characterized by the absence of a terminal condition.¹³¹ However, even in the absence of a terminal condition, the patient may still be in a severely debilitated condition characterized by the presence of coma,¹³² substantial brain damage, or persistent vegetative state.¹³³ Thus, the primary distinction is that

125. See *supra* notes 93-121 and accompanying text.

126. See *infra* notes 141-89 and accompanying text.

127. See *supra* notes 108-21 and accompanying text. Courts will generally employ the substituted judgment test, the best interests test, or a combination or variation thereof to determine the right of the noncompetent patient to refuse medical treatment.

128. See *Dignified Death*, *supra* note 35, at 704.

129. For a discussion of judicially determined guardianship proceedings, see *Severns v. Wilmington Medical Center, Inc.*, 421 A.2d 1334, 1344-45 (Del. 1980); *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 755-59, 370 N.E.2d 417, 432-35 (1977).

130. See generally UNIF. GUARDIANSHIP AND PROTECTIVE PROCEEDINGS ACT, 8A U.L.A. 437 (1989); Quinn, *The Best Interests of Incompetent Patients: The Capacity for Interpersonal Relationships as a Standard for Decisionmaking*, 76 CALIF. L. REV. 897 (1988).

131. See *supra* note 21 and accompanying text for a definition of terminal condition.

132. Coma is characterized by "the absence of consciousness or the lack of both wakefulness and awareness." Johnson, *Withholding Fluids and Nutrition: Identifying the Populations at Risk*, 2 ISSUES IN L. & MED. 189, 191-92 (1986). Coma is also characterized by a sleeplike state of unarousal resulting from damage to the brain stem. Cranford, *supra* note 4, at 28.

133. See Johnson, *supra* note 132, at 195 (noting that PVS "is characterized by irre-

in a terminal condition, death is imminent regardless of the use of life sustaining measures, or the application of life sustaining procedures merely postpones the time of death.

B. Distinctions: Ordinary Treatment versus Extraordinary Treatment; Nutrition and Hydration versus Other Medical Treatment

1. Ordinary Treatment versus Extraordinary Treatment

Courts have drawn two distinctions which impact upon the withdrawal or withholding of life sustaining medical treatment from the noncompetent patient: (1) ordinary treatment versus extraordinary treatment;¹³⁴ and (2) nutrition and hydration versus other medical treatment.¹³⁵ The first distinction arises between medical treatment which is considered to be "ordinary" as opposed to treatment which is deemed to be "extraordinary." Ordinary measures are medication, treatment, and procedures which provide a "reasonable hope of benefit for the patient and which can be obtained and used without excessive expense, pain, or other inconvenience."¹³⁶ Extraordinary measures may be viewed as the converse of ordinary measures.¹³⁷ Some courts have predicated the noncompetent patient's right to refuse life sustaining medical treatment upon the "extraordinary" nature of the treatment, and have allowed the discontinuance of medical treatment only if the treatment is found to be extraordinary.¹³⁸ However, other courts have disregarded the distinction between ordinary and extraordinary treatment, and have determined the discontinuance of treatment independent of whether the life sus-

versible cessation of cognitive or higher functions of the brain but persistence of the vegetative functions of the brainstem"); see also *supra* note 4 and accompanying text.

134. See *infra* note 138 for cases permitting the refusal of extraordinary medical treatment.

135. See cases cited *infra* note 140.

136. Quinn, *supra* note 130, at 919 n.135; see also E. KLUGE, *THE ETHICS OF DELIBERATE DEATH* 18-21 (1981).

137. "Extraordinary" measures are medication, treatment, and procedures which are costly, produce excessive pain or inconvenience, or measures which do not provide a "reasonable hope of benefit." Quinn, *supra* note 130, at 919 n.135; see also E. KLUGE, *supra* note 136, at 19 (extraordinary measures are extremely expensive, painful, difficult, or dangerous).

138. See, e.g., *Foody v. Manchester Memorial Hosp.*, 40 Conn. Supp. 127, 135-37, 482 A.2d 713, 719-20 (1984) (respirator classified as extraordinary treatment, therefore removal allowed); *John F. Kennedy Memorial Hosp., Inc., v. Bludworth*, 452 So. 2d 921, 926 (Fla. 1984) (life support equipment classified as extraordinary measure, therefore removal permitted).

taining measure is extraordinary in nature.¹³⁹

2. Nutrition and Hydration versus Other Medical Treatment

The second distinction made in regard to life sustaining medical treatment is whether nutrition and hydration should be classified as life sustaining medical treatment. Courts generally view nutrition and hydration as a form of life sustaining medical treatment,¹⁴⁰ and therefore, the noncompetent patient has the right to refuse nutrition and hydration in the same manner as other medical treatment.

C. Diversity: A Comparative Survey

A comparative survey of several recent cases¹⁴¹ addressing the right of the noncompetent nonterminally ill patient to refuse life sustaining medical treatment reveals that courts use a broad range of tests and analyses¹⁴² to grant or deny this right. The continuum ranges from nonrecognition and subsequent denial¹⁴³ of the right to refuse medical treatment, to the complete preservation of the noncompetent nonterminally ill patient's right to refuse medical treatment, albeit through the employment of a wide variety of tests.¹⁴⁴ Thus, no definitive standard exists to determine whether the noncompetent nonterminally ill patient has the right to refuse medical treatment, nor is there, in the event that the right is granted, a definitive test employed to determine the method or procedure whereby the patient's right may be exercised.

1. *In re Browning*: Substituted Judgment and Up-to-date Evidence Test

In *In re Browning*,¹⁴⁵ the court adopted the substituted judgment

139. See *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 1019, 195 Cal. Rptr. 484, 491 (1983); *In re Severns*, 425 A.2d 156, 159-60 (Del. Ch. 1980); *In re Conroy*, 98 N.J. 321, 370-72, 486 A.2d 1209, 1234-36 (1985).

140. See *In re Gardner*, 534 A.2d 947, 954-55 (Me. 1987); *Conroy*, 98 N.J. at 372-74, 486 A.2d at 1235-37; *In re Grant*, 109 Wash. 2d 545, 559-65, 747 P.2d 445, 452-55 (1987); see also *supra* notes 11, 68 and accompanying text. Thus, the provision of nutrition and hydration is viewed as medical treatment and not maintenance of the patient's life. See *Quinn*, *supra* note 130, at 921-24; *AMA Opinion*, *supra* note 7.

141. See *Rasmussen v. Fleming*, 154 Ariz. 207, 741 P.2d 674 (1987); *In re Browning*, 543 So. 2d 258 (Fla. Dist. Ct. App. 1989); *Cruzan v. Harmon*, 760 S.W.2d 408 (Mo. 1988), *cert. granted sub nom. Cruzan v. Director, Mo. Dep't of Health*, 109 S. Ct. 3240 (1989); *In re Peter*, 108 N.J. 365, 529 A.2d 419 (1987); see also *infra* notes 145-89 and accompanying text.

142. *Rasmussen*, 154 Ariz. at 221-22, 741 P.2d at 688-89 (best interests test); *Browning*, 543 So. 2d at 272-73 (substituted judgment test); *Peter*, 108 N.J. at 384-85, 529 A.2d at 429 (*Conroy* subjective test used if clear and convincing evidence present; if not, *Quinlan* approach used).

143. *Cruzan*, 760 S.W.2d at 418, 426.

144. See *supra* notes 108-21 and accompanying text.

145. 543 So. 2d 258 (Fla. Dist. Ct. App. 1989). *Browning* involved an 89-year-old

test, but coupled it with a requirement that the surrogate decisionmaker obtain up-to-date evidence on four key issues.¹⁴⁶ The court also formulated comprehensive guidelines¹⁴⁷ to determine the right of the noncompetent nonterminally ill patient to refuse medical treatment. In fashioning a remedy which is applicable to all cases involving adult incompetence, regardless of the patient's prognosis or mental condition,¹⁴⁸ the court adopted an approach which diverges from most case law in this area.¹⁴⁹ Through this standard, the court sought to determine the patient's right to refuse medical treatment without drawing a distinction between the terminal or nonterminal condition of the patient or the source of the noncompetence, such as brain damage, persistent vegetative state, or coma.

In adopting comprehensive guidelines, the *Browning* court employed a balancing test to weigh the factors which affect the right to forego life sustaining medical treatment.¹⁵⁰ The primary factors which must be evaluated are the patient's physical condition and mental condition.¹⁵¹ Other factors¹⁵² which may be considered are: the patient's right of privacy and procedures in accord with this right,¹⁵³ the participation of all necessary parties to the decision,¹⁵⁴ the promptness with which the denial or grant of the right must be

noncompetent patient who received sustenance through a nasogastric tube as a result of substantial brain damage due to a massive stroke. *Id.* at 261. Subsequently, the guardian's petition to have the nasogastric tube removed was denied. *Id.* at 274. The district court of appeal held that the guardian could make the decision to terminate life support measures and granted the guardian's motion for rehearing in light of the comprehensive guidelines established by the court. *Id.* at 274-75.

146. See *infra* notes 158-61 and accompanying text for a discussion of the four issues.

147. The court adopted this approach for two main reasons: (1) to avoid minor variations in diagnosis and definition which often lead to incongruous results; and (2) to adapt to and accommodate change in technology and perspective. *Browning*, 543 So. 2d at 268.

148. *Id.*

149. Most courts distinguish noncompetent patients on the basis of the presence or absence of a terminal or nonterminal condition. Moreover, courts often deny or grant the noncompetent patient's right to refuse medical treatment based on the nature of the incompetency, such as coma, persistent vegetative state, or brain damage. See *supra* notes 93-121 and accompanying text.

150. *Id.* at 268-69. Another type of balancing approach used by courts is a cost benefit analysis, coupled with a limited resource approach. See generally Alexander, *Death by Directive*, 28 SANTA CLARA L. REV. 67 (1988).

151. *Browning*, 543 So. 2d at 268.

152. *Id.* at 268-69.

153. *Id.* at 269.

154. The court based the noncompetent nonterminally ill patient's right to refuse medical treatment on Florida's constitutional right of privacy. *Id.* at 266-67.

made,¹⁵⁵ the use of the substituted judgment test by the surrogate decisionmaker in the exercise of the decision,¹⁵⁶ and the recognition by the surrogate decisionmaker of the importance of the countervailing state interests.¹⁵⁷

In addition to the adoption of the balancing test, the *Browning* court held that the surrogate decisionmaker must obtain current evidence on four issues in order to choose to forego life sustaining medical treatment on behalf of the noncompetent patient:¹⁵⁸

- (1) Is the patient suffering from a medical condition which would permit the patient, if competent, to forego life-sustaining medical treatment?¹⁵⁹
- (2) Is there any reasonable probability that the patient will regain competency so that this right could be self-exercised by the patient?¹⁶⁰
- (3) Is the patient's personal decision on this subject sufficiently clear that the guardian can make a substituted judgment?
- (4) Is the patient's right to forego medical treatment outweighed by state interests under the *Satz* standards?¹⁶¹

155. The decision must be made promptly to avoid a situation in which the right to refuse medical treatment is granted after the patient has died. For cases in which the patient died before the final judgment was rendered, but the court did not render the issue nonjusticiable despite mootness, see, e.g., *Rasmussen v. Fleming*, 154 Ariz. 207, 313-14, 741 P.2d 674, 680-81 (1987) (issue of public importance which is capable of repetition yet avoiding review); *Bartling v. Superior Court*, 163 Cal. App. 3d 186, 189, 209 Cal. Rptr. 220, 221 (1984) (issue capable of repetition); *In re L.H.R.*, 253 Ga. 439, 439-40, 321 S.E.2d 716, 718 (1984) (issue capable of repetition yet avoiding review); *In re Farrell*, 108 N.J. 335, 347, 529 A.2d 404, 410 (1987) (issue of extreme importance likely to arise in the future).

156. Furthermore, the court adopted procedures outlining the scope of judicial review in the event that the surrogate decisionmaker chooses to exercise the patient's right to refuse medical treatment outside of the judicial forum. *Browning*, 543 So. 2d at 273-74. The court is empowered to review the surrogate's decision regarding the patient's medical condition, the competency of the patient, the choice the patient would have made if competent, and the countervailing state interests. *Id.* In reviewing the surrogate's decision, the court must determine that the decisionmaker adhered to rules of law, based the decision upon clear and convincing evidence, and acted in good faith. *Id.* Moreover, the court also must determine independently that the state's interests do not override the patient's right to refuse medical treatment. *Id.*

157. See *supra* notes 75-92 and accompanying text for a discussion of the countervailing state interests.

158. *Browning*, 543 So. 2d at 271. Moreover, the evidence must satisfy the clear and convincing standard. *Id.* at 273; see *supra* note 107 for a definition of clear and convincing evidence.

159. All available medical evidence, including certificates made by physicians, must be considered in order to determine the patient's medical condition. *Browning*, 543 So. 2d at 271. The certificates should contain information on the patient's present medical status, the amount of pain the patient experiences, the medical treatment sought to be withdrawn, the prognosis, and a determination by the physician as to whether termination of treatment is consistent with medical ethics. *Id.* at 271-72.

160. If a reasonable probability exists, then the decision to forego medical treatment must be postponed. *Id.* at 272.

161. See *Satz v. Perlmutter*, 362 So. 2d 160 (Fla. Dist. Ct. App. 1978), *approved*, 379 So. 2d 359 (Fla. 1980). In *Satz*, the court followed the traditional balancing test to determine the right of a competent, terminally ill patient to remove a mechanical respirator. *Id.* at 161-64. The *Satz* court balanced the patient's right to refuse medical treatment based on the constitutional right of privacy and the common law right of bodily integrity against the countervailing state interests of the preservation of life, the

Through the adoption of comprehensive guidelines that balance those factors which impact the decision to forego medical treatment, and the use of current evidence on the four aforementioned issues, the *Browning* court sought to provide workable and flexible guidelines to aid in the determination of the patient's right to refuse medical treatment. The *Browning* court has formulated a uniform approach which will eliminate the minor variations, albeit often not legally justifiable, which frequently characterize decisions in this area. The inherent flexibility also will accommodate change in medical technology as well as in ethical and legal perspectives.

2. *In re Peter: Conroy and Quinlan Revisited*—The Hierarchical Approach

In *In re Peter*,¹⁶² the New Jersey Supreme Court turned to two of its seminal decisions, *In re Quinlan*¹⁶³ and *In re Conroy*,¹⁶⁴ for assistance, and subsequently fashioned a hierarchical two-step approach¹⁶⁵ to determine the right of the noncompetent nonterminally ill patient to refuse medical treatment. The *Peter* court specifically indicated that the noncompetent nonterminally ill patient should be granted the right to refuse medical treatment: "[a]ll patients, competent or incompetent . . . terminally ill or not terminally ill, are entitled to choose whether or not they want life-sustaining medical treatment."¹⁶⁶

Applying a two-step hierarchical approach, the *Peter* court held that if clear and convincing evidence exists that the patient would refuse treatment if competent, then the *Conroy* subjective test,¹⁶⁷

protection of third parties, the prevention of suicide, and the maintenance of the ethical integrity of the medical profession. *Id.*; see *supra* notes 37-92 and accompanying text.

162. 108 N.J. 365, 529 A.2d 419 (1987).

163. 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976).

164. 98 N.J. 321, 486 A.2d 1209 (1985).

165. See *infra* notes 167-69 and accompanying text for explanation.

166. *Peter*, 108 N.J. at 372, 529 A.2d at 423 (emphasis added).

167. The *Conroy* court formulated three tests to guide the determination of the patient's right to forego medical treatment. *Conroy*, 98 N.J. at 360-61, 365-67, 486 A.2d at 1229, 1232. The first test is known as the "subjective" test, and is analogous to the substituted judgment test adopted by other courts. The subjective test is employed when there is clear and convincing evidence that the patient would refuse medical treatment if the patient were competent. Thus, the patient's right may be exercised through the substituted judgment of the surrogate decisionmaker. *Id.* at 360-61, 486 A.2d at 1229.

The second test established is known as the "limited-objective" test. It is employed when clear and convincing evidence is absent although "some trustworthy evidence" exists that the patient would have chosen to refuse treatment, and the burdens of con-

which is akin to the substituted judgment test, should be applied. However, if clear and convincing evidence is absent, the guidelines and procedures established in *Quinlan* should be used to determine the noncompetent nonterminally ill patient's right.¹⁶⁸ Under *Quinlan*, the surrogate decisionmaker must decide that the patient would forego medical treatment, the attending physician must concur in this decision, and the patient's medical condition must be substantiated by both the attending physician and the hospital ethics committee in order to support the right to refuse medical treatment.¹⁶⁹

Under both the *Conroy* and *Quinlan* standards adopted by the *Peter* court, the surrogate decisionmaker must seek to make the decision regarding the acceptance or rejection of medical treatment that the noncompetent patient would make if competent. However, the right to refuse medical treatment is limited under each test. The *Conroy* subjective test is limited by the requisite standard of clear and convincing evidence which must be satisfied in order for the right to be granted.¹⁷⁰ Although not restricted by the clear and convincing evidence standard,¹⁷¹ the *Quinlan* approach is limited by the procedural guidelines necessary to support the patient's right to refuse medical treatment.¹⁷² Nevertheless, the *Peter* court has sought to preserve the noncompetent nonterminally ill patient's right to refuse medical treatment through a substituted judgment analysis, regardless of the degree of evidence present.

3. *Rasmussen v. Fleming*: The Best Interests Test

In *Rasmussen v. Fleming*,¹⁷³ the Supreme Court of Arizona pri-

tinued existence outweigh the benefits received by the patient. *Id.* at 365-66, 486 A.2d at 1232.

The final test formulated is known as the "pure-objective" test and is used when there is no evidence of the patient's wishes regarding the acceptance or rejection of medical treatment. *Id.* at 366-67, 486 A.2d at 1232. Under the pure-objective test, for treatment to be terminated the burdens of existence resulting from the administration of the treatment must "clearly and markedly" outweigh the benefits received by the patient, and the continued administration of the treatment must be deemed to be inhumane because of the pain produced by the treatment. *Id.*

168. *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976).

169. *Id.* at 54, 355 A.2d at 671.

170. *Peter*, 108 N.J. at 377-78, 529 A.2d at 425 (*Conroy* subjective test applicable only if clear and convincing evidence present that patient would refuse treatment if competent).

171. As the *Quinlan* approach is employed in the absence of clear and convincing evidence, this standard of evidence is not a prerequisite. Rather, surrogate decisionmakers must exercise their "best judgment" in determining whether medical treatment should be refused. *Id.* (citing *Quinlan*, 70 N.J. at 41, 355 A.2d at 664).

172. See *supra* note 169 and accompanying text.

173. 154 Ariz. 207, 741 P.2d 674 (1987). *Rasmussen* involved a nonterminally ill patient who was in a persistent vegetative state as a result of strokes and subsequent neuromuscular or brain damage. *Id.* at 212, 741 P.2d at 679. The guardian petitioned to

marily focused on the best interests test¹⁷⁴ to determine the right of the noncompetent nonterminally ill patient to forego life sustaining medical treatment. Although the court did not specifically adopt the substituted judgment test, it indicated that the substituted judgment test was primarily limited to situations in which the noncompetent patient had expressed a preference for rejection or acceptance of medical treatment while competent.¹⁷⁵ The *Rasmussen* court indicated that in the absence of such an expressed preference or “[w]here no reliable evidence of a patient’s intent exists . . . the substituted judgment standard provides little, if any, guidance to the surrogate decisionmaker and should be abandoned in favor of the ‘best interests’ standard.”¹⁷⁶ The court concluded that the best interests of a patient in a chronic vegetative state, but nonterminal condition, would be best advanced by the placement of “Do not Resuscitate”¹⁷⁷ and “Do not Hospitalize” orders on the patient’s records; thus, the court subsequently granted the patient’s right to refuse medical treatment.¹⁷⁸

The *Rasmussen* decision is noteworthy because the court concluded that the best interests of the patient would be served by granting the patient’s right to *forego* life sustaining measures, contrary to the traditional presumption in favor of life and administration of medical treatment which is presumed to characterize the best interests test.¹⁷⁹ Thus, although the *Rasmussen* court applied the traditional

have DNR (“do not resuscitate”) and DNH (“do not hospitalize”) orders placed on the patient’s medical records. *Id.*

174. See *supra* notes 118-21 and accompanying text for a discussion of the “best interests” test.

175. *Rasmussen*, 154 Ariz. at 221-22, 741 P.2d at 688-89; see *Barber v. Superior Court*, 147 Cal. App. 3d 1006, 1021, 195 Cal. Rptr. 484, 493 (1984); *Foody v. Manchester Memorial Hosp.*, 40 Conn. Supp. 127, 139-40, 482 A.2d 713, 721-22 (1984); *In re Conroy*, 98 N.J. 321, 364, 486 A.2d 1209, 1231 (1985) (“[I]n the absence of adequate proof of the patient’s wishes, it is naive to pretend that the right to self-determination serves as the basis for substituted decision-making.”); see also *supra* notes 114-17 and accompanying text.

176. *Rasmussen*, 154 Ariz. at 222, 741 P.2d at 689.

177. See generally Rabkin, Gillerman & Rice, *Orders Not to Resuscitate*, in *ETHICAL ISSUES IN DEATH AND DYING* 176 (1978); Robertson, *Legal Criteria for Orders Not to Resuscitate: A Response to Justice Liacos*, in *LEGAL AND ETHICAL ASPECTS OF TREATING CRITICALLY AND TERMINALLY ILL PATIENTS* 159 (1982).

178. *Rasmussen*, 154 Ariz. at 222, 741 P.2d at 689. Under the best interests standard, an accurate evaluation “will encompass consideration of the satisfaction of present desires, the opportunities for future satisfactions, and the possibility of developing or regaining the capacity for self-determination.” PRESIDENT’S REPORT, *supra* note 95, at 135.

179. See *supra* notes 118-21 and accompanying text.

test, which militates against the termination of life sustaining medical treatment, the court, nevertheless, granted the patient's right to forego medical treatment.

4. *Cruzan v. Harmon*: Nonrecognition and Denial of the Right to Refuse Medical Treatment

In *Cruzan v. Harmon*,¹⁸⁰ the court denied the right of a noncompetent nonterminally ill patient to refuse life sustaining medical treatment.¹⁸¹ Although the court appeared to predicate the denial of the right upon the lack of requisite evidence necessary to satisfy the substituted judgment test,¹⁸² the court's denial implicates much broader concerns, as it failed to acknowledge that the noncompetent patient has the right to refuse medical treatment.

By implication, the *Cruzan* court indicated that the right to refuse medical treatment has no basis in the constitutional right of privacy.¹⁸³ The court stated that "we carry grave doubts as to the applicability of privacy rights to decisions to terminate the provision of food and water to an incompetent patient."¹⁸⁴ The court further implied that the noncompetent patient may not have a common law right to refuse medical treatment¹⁸⁵ because the informed consent necessary for refusal is absent due to the noncompetency of the pa-

180. 760 S.W.2d 408 (Mo. 1988), *cert. granted sub nom.* *Cruzan v. Director, Mo. Dep't of Health*, 109 S. Ct. 3240 (1989); *see supra* notes 1-3 and accompanying text for discussion of the factual situation in the *Cruzan* case.

181. *Cruzan*, 760 S.W.2d at 426. The *Cruzan* court held:

that the co-guardians do not have authority to order the withdrawal of hydration and nutrition to Nancy. We further hold that the evidence offered at trial as to Nancy's wishes is inherently unreliable and thus insufficient to support the co-guardians claim to exercise substituted judgment on Nancy's behalf. The burden of continuing the provision of food and water, while emotionally substantial for Nancy's loved ones, is not substantial for Nancy. The State's interest is in the preservation of life, not only Nancy's life, but also the lives of persons similarly situated yet without the support of a loving family. This interest outweighs any rights invoked on Nancy's behalf to terminate treatment in the face of the uncertainty of Nancy's wishes and her own right to life.

Id.

182. *Id.* The patient's co-guardians advocated that the patient's statements alone, which expressed a preference for the refusal of medical treatment, were sufficient evidence to satisfy the substituted judgment test. *Id.* at 424. However, the court held that the requisite clear and convincing standard of evidence had not been met, and therefore denied the patient's right to refuse medical treatment. *Id.* at 426. The court stated that "'informally expressed reactions to other people's medical condition and treatment do not constitute clear proof of a patient's intent.'" *Id.* at 424 (citations omitted).

183. *See id.* at 418. This clearly is against the weight of authority, as courts generally predicate the right to refuse medical treatment, either in part or in whole, upon the fundamental right of privacy. *See supra* notes 46-61 and accompanying text.

184. *Cruzan*, 760 S.W.2d at 418.

185. The right to refuse medical treatment is often based upon the common law right of bodily integrity. *See supra* notes 41-45 and accompanying text.

tient.¹⁸⁶ Thus, in effect, the *Cruzan* court failed to acknowledge that the noncompetent patient has the right to refuse medical treatment.

Despite the initial nonrecognition of the right to refuse medical treatment, the *Cruzan* court proceeded to balance the patient's interest against the countervailing state interests, particularly the state's interest in the preservation of life.¹⁸⁷ The court subsequently subordinated the right of the noncompetent nonterminally ill patient to forego medical treatment and the concomitant choice to not be sustained in a persistent vegetative state to the state's interest in the preservation of life.¹⁸⁸ This subordination of the patient's right may be deemed an anomaly because the right to refuse medical treatment is predicated upon the fundamental right of privacy guaranteed by the Constitution.¹⁸⁹ However, the *Cruzan* court did not consider this an incongruous result; it simply failed to recognize that the noncompetent patient has the right to refuse medical treatment. Thus, not only did the *Cruzan* court completely abridge the exercise of the right to refuse medical treatment, but it failed to even acknowledge the existence of such a right.

V. CONCLUSION

It is well established that the competent patient has the right to refuse life sustaining medical treatment based upon the common law right of bodily integrity, the constitutional right of privacy, and the statutory rights embodied in natural death acts. Moreover, courts have extended the right to refuse medical treatment and the concomitant choice to "die with dignity" to the noncompetent terminally ill patient, primarily due to the terminal condition of the patient characterized by imminent death and the absence of hope of recovery.

186. *Cruzan*, 760 S.W.2d at 417. The court indicated that the doctrine of informed consent contained three prerequisites: (1) the patient must have the ability to reason and make decisions; (2) the decision must be voluntary and made without force; and (3) the patient must understand the nature of the illness, the prognosis, and the risks and benefits of treatment or nontreatment. *Id.* Moreover, the court stated that "[i]n the absence of these three elements, neither consent nor refusal can be informed." *Id.* Thus, the court implied that the noncompetent patient does not have the right to refuse medical treatment, because the patient is unable to understand the risks and benefits of nontreatment and, therefore, lacks the ability to make an informed refusal.

187. The *Cruzan* court noted that the state had a two-fold interest in the preservation of life: (1) the prolongation of life; and (2) the sanctity of life. *Id.* at 419.

188. *Id.* at 424 (noting that right to refuse medical treatment, regardless of source of right, does not outweigh the "immense, clear fact of life in which the state maintains a vital interest").

189. *See supra* notes 46-61 and accompanying text.

However, because the law is unsettled as it applies to the noncompetent nonterminally ill patient, a wide variety of tests and analyses are employed to determine both the existence and exercise of the right to refuse medical treatment. The primary tests used to determine the exercise of this right, the substituted judgment test and the best interests test, often produce incongruous results and are subject to great manipulation and inconsistent interpretation. To ensure that the noncompetent nonterminally ill patient receives the full complement of rights already accorded to competent and noncompetent terminally ill patients, more workable and flexible standards are needed to determine both the existence and exercise of the right to refuse medical treatment. The comprehensive, structured, yet flexible guidelines formulated in *In re Browning* provide an appropriate standard which may be used to preserve and protect the noncompetent nonterminally ill patient's right to refuse medical treatment, while maintaining the integrity of the state's counterbalancing interests.

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